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**Addictions & Mental Health Ontario**

# Addiction Supportive Housing Implementation Review

# Program Snapshot

Johnston Consulting

September, 2013

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# ASH Implementation Review
# PROGRAM SNAPSHOT

## 1. Introduction

In August 2011 the Ontario Federation of Community Mental Health and Addiction Programs (the Federation) received funding from Health Canada to undertake a review of Ontario's newly developing Addiction Supportive Housing (ASH) Programs. The Federation commissioned Valerie Johnston and Janine Gates of Johnston Consulting to undertake that review.

This is the third of four reports produced in fulfillment of the project's deliverables:

1) *Addictions Supportive Housing: Literature Review*
2) *Addictions Supportive Housing: Report on Client Focus Groups*
3) ***Addictions Supportive Housing: Program Snapshot***
4) *Addictions Supportive Housing: Evolving Practices – Interim Report*

Together, those reports present a comprehensive picture of the ASH programs funded across Ontario, an early assessment of their performance, and a comparison with similar programs in other jurisdictions.

This Snapshot describes Ontario's ASH programs in terms of eleven key dimensions across four characteristics:

1. Date of Implementation
2. Agency Partnerships[1]:
    a. Funding Transfers
    b. Rent Supplement Agency Role
3. Housing Profile:
    a. Duration[2]
    b. Type[3]
    c. Leasing Arrangements
4. Program Profile:
    a. Client/Case Manager Ratio
    b. Program Approach[4]

[1] The 'partnerships' described in this report are those that exist between the agencies that provide ASH Case Management Services and those that administer ASH rent supplements.
[2] 'Duration' refers to the length of time for which supportive housing is available to ASH clients/tenants
[3] 'Type' describes the physical configuration of supportive housing units.
[4] 'Program Approach' refers to the program's orientation and approach with respect to clients' substance use goals.

## 1.1 Background

In March 2008 the Ministry of Health and Long-Term Care (MOHLTC) committed $16 million for the development of 1,000 supportive housing units across Ontario for people with addictions. In its presentation to the field, The MOHLTC cited the following objectives for those new system resources:[5]

- *To reduce the frequency of re-admissions to addiction programs, and particularly to withdrawal management services*
- *To increase housing stability for people with problematic substance abuse who are homeless, at risk of homelessness or inadequately housed*
- *To reduce pressures on the emergency care and acute care system*

The target population was described as follows:

*Persons with problematic substance use who:*

- *Are involved in or completed an addiction treatment program;*
- *Are high users of the addiction system*
- *Are homeless, at risk of homelessness or inadequately housed*
- *Are assessed as having a high probability of being successful in supportive housing.*

The plan noted that: *People receiving methadone maintenance treatment or with HIV/AIDS will not be excluded.*

The MOHLTC also articulated principles for service development and delivery – at both the system and program levels. *Principles for Local Program Design* provided direction to the Local Health Integration Networks (LHINs) with respect to stakeholder involvement in the planning process, definition of the target population, and the criteria to be applied when assessing proposals:

***Principles for Local Program Design:***

- *Participation of client target group in planning and implementation of models*
- *LHIN planning processes to include representation from addiction agencies and mental health and other health and social service providers, e.g. AIDS service organizations*
- *Targeted to people with problematic substance use who are homeless or at risk of homelessness*
- *Support is flexible and variable depending on client needs*
- *Built on existing service system links to on-going community support services*
- *Collaboration in service delivery to clients is expected*
- *Housing support must be accompanied by corresponding community support services such as case management or crisis services*

[5] Presentation by Anne Bowlby and Brian Davidson, Ministry of Health and Long-Term Care, to addiction service agencies, September 30, 2008.

- *Case management services will be funded at client/staff ratio of 8:1; no housing provider receives less than 8 units*
- *Housing provider has experience providing rent supplement units.*

*Principles for Program Framework* defined criteria for service delivery models which would be deemed eligible for the new funding, described access mechanisms, and identified the MOHLTC's intended approach to outcome measurement and accountability:

***Principles for Program Framework:***

- *Program is client-centred and responsive to the unique needs of individuals*
- *Services are based on a 'Housing First'* [6] *model for supportive housing*
- *Program is responsive to relapsing nature of problematic substance use*
- *Services are based on a harm reduction approach and recovery model*
- *Housing is integrated into the community*
- *Clients should feel safe and secure in housing environment*
- *Mental health and addictions support services (are) provided through integrated, multi-disciplinary teams, e.g. housing coordination and addiction support services*
- *'No wrong door' regional coordination of access, application process*
- *Build on existing data systems in place such as the Drug and Alcohol Treatment Information System (DATIS) to measure client outcomes and ensure program accountability*

***Service Provider Eligibility Criteria:***

At the same time, the MOHLTC identified a number of criteria for service providers, noting that:

*Preference will be given to providers that have experience with:*

- *The target population*
- *Demonstrated partnership experience with the addiction and mental health system (e.g. referral sources, access to treatment, rehab, medical, social and peer support services)*
- *Knowledge of best practices in provision of addiction services*
- *Staff skilled and knowledgeable with both addiction treatment and mental health treatment (for concurrent disorders)*
- *Experience with or ability to partner with a TP* (transfer payment*) agency who has administered rent supplement supportive housing units, including experience with the Residential Tenancies Act and landlord/tenant issues*

[6] Based on the Housing First program in New York City, Housing First is a model of housing support that focuses on providing permanent housing for chronically homeless individuals, particularly those with mental illness and/or substance use issues. Housing is provided without a requirement for engagement with treatment services; instead, people can choose to receive the individual services and assistance, as needed, from staff of Housing First programs.

- *Ability to submit all mandatory documentation and data, including complying with evaluation requirements*
- *Ability to implement initiative in a timely manner.*

Having established that foundation, the MOHLTC then allocated funding to each of the province's 14 LHINs, which further refined the criteria to reflect the specific needs and resources of its own community. Once funded to provide ASH services, each of the agencies then developed its own ASH program in a manner that, based on that agency's experience and expertise, would best meet the needs of its clients.

## 1.2 Process

The findings in this report are the product of the following 10-step process:

1. Interviews with representatives of the MOHLTC and the LHINs to develop a comprehensive list of funded agencies[7, 8] (Nov/11 to Jan/12)
2. Development and distribution of a questionnaire to obtain basic information from ASH agencies[9] (Dec/11)
3. Presentation to the Addictions Ontario Residential Services Community of Practice (AO CoP) meeting to introduce the project and elicit agencies' cooperation in collecting the necessary information (Dec 8/11)
4. Discussions with staff of ConnexOntario and DATIS to reconcile our ASH agency inventories. (Jan/12)
5. Development of a program review template to obtain detailed information from ASH agencies[10] (Aug/12)
6. Interviews with key staff (Executive Directors or their designates) in ASH programs to clarify information provided in the December/11 questionnaire and to obtain additional program details[11] (Sept/12 to Dec/12)
7. Development of a draft 'snapshot' describing ASH agencies in Ontario (Nov/12)
8. Presentation to the AO CoP to review and obtain feedback about the draft snapshot (Nov 27/12)
9. Communication with each of the agencies to confirm its program profile (Nov/12 to Mar/13)
10. Development of the final program profile for each funded agency and the provincial snapshot. (Jan/13 – Mar/13)

[7] *Appendix A: Key Informants: MOHLTC and LHINs*
[8] Because rent supplements were funded directly by the MOHLTC, and case managers were funded by the LHINs, there was no consolidated list of agencies
[9] *Appendix B: Questions for ASH Agencies*
[10] *Appendix C: Program Profile Template*
[11] *Appendix D: Agency Key Informants*

# 2. Findings

Every effort was made to ensure that the findings described in this report were accurate as of the time of writing. However, two important caveats must be noted:

- Service design is, and should be, dynamic. ASH programs have been evolving since funding was first provided. Some of the earliest-funded ASH programs have already modified elements of their programs (or identified the need to do so) in response to their early learning about what works.
- Conversely, a small number of ASH programs have only recently become operational. A few had just housed their first client when the majority of interviews were conducted in December 2012. The last to be funded planned to house its first tenant on April 1, 2013. Obviously, those programs were not fully mature at the conclusion of this study and may well be adjusted as they gain experience.

## 2.1 Program Inventory

Our review identified the following:

- Forty-one (41) unique agencies funded to provide Case Management services
- One hundred seventeen (117) Full Time Equivalent (FTE) Case Managers
- Forty-five distinct 'programs' operated by the Case Management agencies[12]
- Forty-two unique agencies funded to administer rent supplements[13]
- Nine hundred ninety-six (996) rent supplements funded[14]

LHIN–by-LHIN allocations are detailed in the charts on the following pages:

[12] Three agencies (ADAPT, Addiction Services Muskoka Parry Sound and COPA) provide service in more than one LHIN, while one (CAMH) provides services for two distinct populations in the same LHIN. For purposes of this report, each separate configuration of resources constitutes a 'program'.

[13] As indicated in the Background section, the MOHLTC required that agencies administering ASH rent supplements be experienced in that role. Since rent supplements had not been available to the addiction system prior to the development of ASH, most rent supplements are administered by mental health agencies.

[14] Three agencies (St. Stephen's House - TCAT, Sandy Hill Community Health Centre, and CMHA Simcoe) have been approved for staffing ratios less than the 1:8 anticipated by the MOHLTC. Consequently the provincial ratio of case managers to rent supplements is 1: 8.51.

| LHIN | CASE MANAGEMENT AGENCY | # of CASE MGRS FUNDED | RENT SUPPLEMENT AGENCY | # of RENT SUPPS FUNDED |
|---|---|---|---|---|
| #1: Erie St. Clair | CMHA Lambton-Kent | 2 | CMHA Lambton-Kent | 16 |
| | House of Sophrosyne | 1 | CMHA Windsor Essex | 8 |
| #2: Southwest | Addiction Services of Thames Valley | 4 | WOTCH Comm. Mental Health Services | 16 |
| | | | CMHA Oxford-Woodstock | 4 |
| | | | CMHA Elgin-St. Thomas | 4 |
| | | | SEARCH Community Services | 8 |
| | Choices for Change | 1 | CMHA Huron Perth | 8 |
| | HopeGreyBruce | 1 | HopeGreyBruce | 8 |
| #3: Waterloo Wellington | House of Friendship | 3 | CMHA Grand River | 24 |
| | Stonehenge | 3 | CMHA Grand River | 24 |
| #4: Hamilton Niagara Haldimand Brant | Community Addiction Services of Niagara | 5 | CMHA Niagara/Gateway | 40 |
| | Halton ADAPT | 2 | Summit House | 16 |
| | Womankind | 2 | CMHA Hamilton | 16 |
| | Wayside House | 2 | CMHA Hamilton | 16 |
| | Mission Services (Suntrac) | 2 | CMHA Hamilton | 16 |
| | St. Leonard's Community Services | 1 | St. Leonard's Community Services | 8 |
| | Holmes House (Norfolk General Hospital) | 1 | CMHA Haldimand Norfolk | 8 |
| | Six Nations Mental Health Services | 1 | Six Nations Mental Health Services | 8 |
| #5: Central West | Peel Addiction Assessment and Referral Centre | 2 | Supportive Housing in Peel | 16 |
| #6: Mississauga-Halton | Halton ADAPT | 2 | Support and Housing Halton | 16 |

| LHIN | CASE MANAGEMENT AGENCY | # of CASE MGRS FUNDED | RENT SUPPLEMENT AGENCY | # of RENT SUPPS FUNDED |
|---|---|---|---|---|
| #7: Toronto Central | Jean Tweed Centre | 4*[15] | Mainstay Community Services | 32 |
| | LOFT Community Services | 4* | Fife House | 32 |
| | Good Shepherd | 4 | Good Shepherd | 32 |
| | Fred Victor | 2 | Fred Victor | 16 |
| | Breakaway | 5* | Regeneration House | 40 |
| | St. Stephens (TCAT) | 8 | Regeneration House | 40 |
| | | | Mainstay | 40 |
| | COPA | 2* | Mainstay | 16 |
| | CAMH | 1 | John Howard Society | 8 |
| | CAMH | 2* | Houselink | 16 |
| #8: Central | Addiction Services York Region | 1 | CMHA York Region | 8 |
| #9: Central East | Pinewood | 4 | CMHA Durham | 32 |
| | FourCAST | 1 | CMHA Peterborough | 8 |
| | COPA | 1 | St. Paul's Lamoureaux | 8 |
| | Homestead | 3 | Homestead | 24 |
| #10: Southeast | Addiction Services Hastings Prince Edward | 6 | Addiction Services Hastings Prince Edward | 48 |
| #11: Champlain | Addiction Services of Eastern Ontario | 4 | Addiction Services of Eastern Ontario | 32 |
| | Sandy Hill CHC | 10 | CMHA Ottawa | 120 |
| | Mackay Manor | 3 | Pembroke Regional Hospital, Community Mental Health | 24 |

[15] Agencies marked with an asterix (*) operate with one fewer case manager than indicated. Funding for the additional FTE is transferred to the agency administering rent supplements to provide one FTE Housing Support Worker. See Section 5: Case Management Services for details.

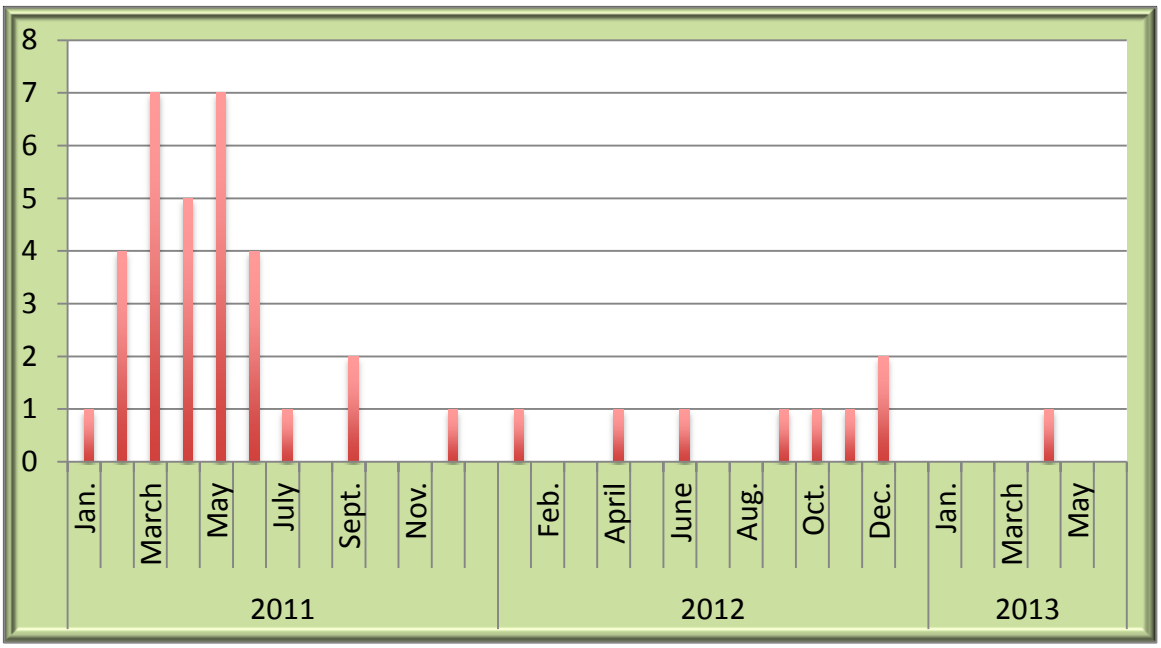
| LHIN | CASE MANAGEMENT AGENCY | # of CASE MGRS FUNDED | RENT SUPPLEMENT AGENCY | # of RENT SUPPS FUNDED |
|---|---|---|---|---|
| # 12: North Simcoe Muskoka | Addiction Outreach Muskoka Parry Sound | 2 | Muskoka Parry Sound Community Mental Health Services | 16 |
| | CMHA Simcoe County | 2[16] | CMHA Simcoe County | 20 |
| # 13: North East | Algoma Public Health | 2 | Algoma Public Health | 16 |
| | Addiction Outreach Muskoka Parry Sound | 1 | Muskoka- Parry Sound Community Mental Health Services | 8 |
| | North Bay Recovery Home | 1.5 | CMHA Nipissing | 12 |
| | Iris | 2 | CMHA Sudbury | 16 |
| | South Cochrane Addiction Services | 1.5 | CMHA Cochrane-Timiskaming | 12 |
| #14: North West | Alpha Court | 3 | Alpha Court | 24 |
| | CMHA Fort Frances | 1 | CMHA Fort Frances | 8 |
| | Lake of the Woods District Hospital | 1 | Kenora Association for Community Living, Community Mental Health Support Services | 8 |
| **TOTAL** | | **117** | | **996** |

[16] CMHA Simcoe County received approval for a third case manager prior to the prorogation of the provincial legislature in October 2102. However, at the time of the interview with this program, funding for that position had not yet been received.

## 2.2 Implementation Timelines

Although ASH funding was first announced in 2008, actual implementation dates varied from LHIN to LHIN and from program to program. One agency reported that it housed its first clients in January 2011, while two others had not yet housed any clients by early December 2012, (although they anticipated that they would do so in the next few weeks). The last program funded indicated that its first tenant would receive the key to the unit on April 1, 2013. The following chart shows the number of ASH programs that housed their first client in each of the 28 months between those dates:

***Figure 1: Program Implementation Timeline***




## 2.3 Partnerships

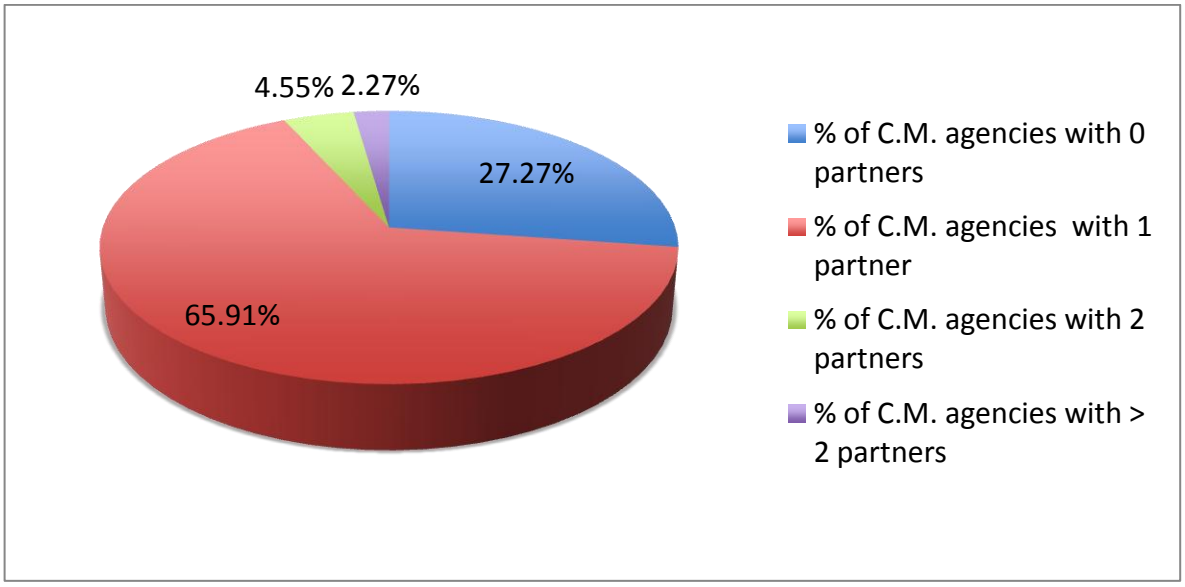
As noted, the MOHLTC's eligibility requirements for service providers included two specific criteria:

- Experience administering rent supplements, and with the *Residential Tenancies Act*
- Experience with the target population and knowledge of best practices in provision of addiction services

Few addiction agencies had experience with rent supplements prior to ASH funding being made available. However, that experience was widespread among mental health agencies, thanks to the long history of supportive housing programs in the mental

health sector. Conversely, few mental health agencies could claim the necessary expertise with the ASH target population. Consequently, almost 75% of ASH programs are delivered through partnerships between mental health and addiction agencies. Typically, each case management agency is engaged in one such partnership. A small number identified multiple ASH partners. The following table illustrates the number of ASH partnerships from the perspective of the case management partner:

***Figure 2: Partnerships per Agency Providing Case Management Services***



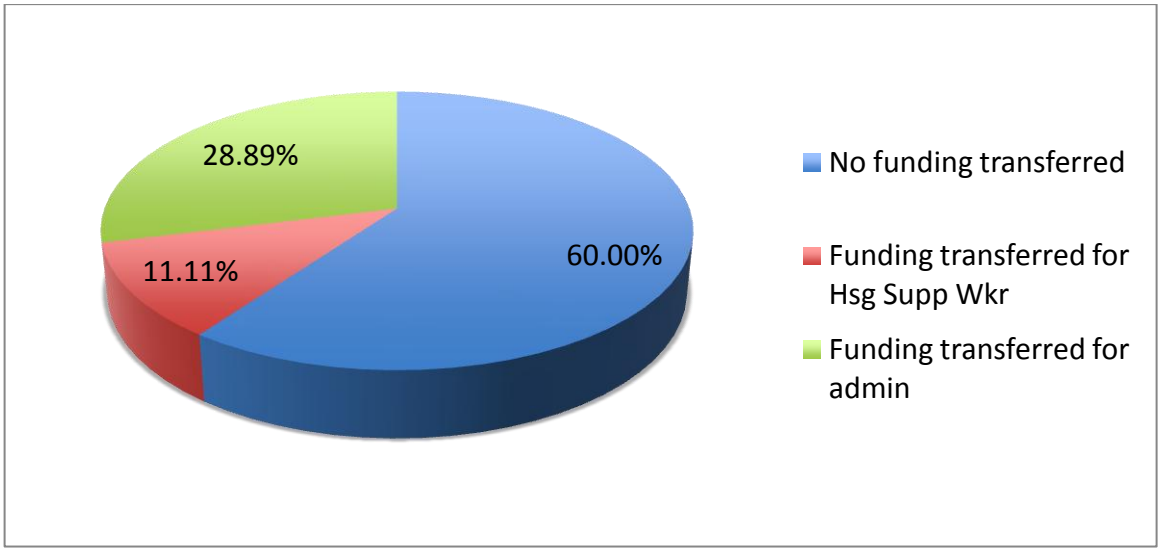

## Funding Transfers

The MOHLTC allocation for ASH rent supplements covers the amount of the supplement only, without any additional funding to offset administrative costs. Since some Rent Supplement agencies expressed reluctance to take on that role without compensation, and some Case Management agencies believed that it was unreasonable to ask their partners to do so, approximately thirty percent of Case Management agencies offer a small stipend[17] to their partners – most often in the form of one-time funding. One Case Management agency reports that it "hired the department" of its Rent Supplement partner to address all housing-related issues.

In a small number of other partnerships (11%), the partner agencies have entered into a purchase of service agreement, in which the Case Management agency funds a Housing Support Worker, employed by the Rent Supplement agency, to support ASH tenants in obtaining and retaining housing.

[17] The amount of funding transferred to offset administrative costs varies widely, however it appears that the maximum agency-to-agency transfer is approximately $3,600.

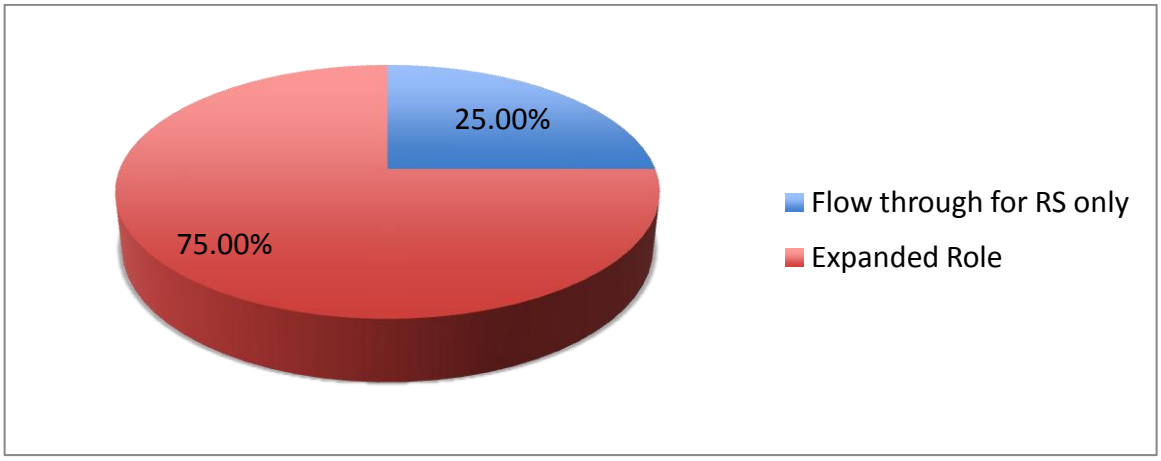
***Figure 3: Agency-to-Agency Funding Transfers***




## Agency Roles

Significant differences were noted in the role of agencies administering ASH rent supplements. In one quarter (25%) of the partnerships, the Rent Supplement Agency was responsible for flowing funding for the rent supplements only, with all other functions handled by the Case Management Agency. In the majority of relationships, however, the Rent Supplement Agency performed a variety of other functions as well – ranging from securing housing, to managing the relationship with the landlord, to supporting the tenant to improve his or her Independent Living Skills.

***Figure 4: Role of Agency Providing Rent Supplements***



## 2.4 Housing Profile

There is considerable variation across the province with respect to the nature, form and structure of ASH housing. The following section details our findings related to:

- the intended duration of tenancy (Figure 5),
- the housing model employed (Figure 6),
- the type of housing (Figure 7), and
- the leasing arrangements (figure 8).

### Duration

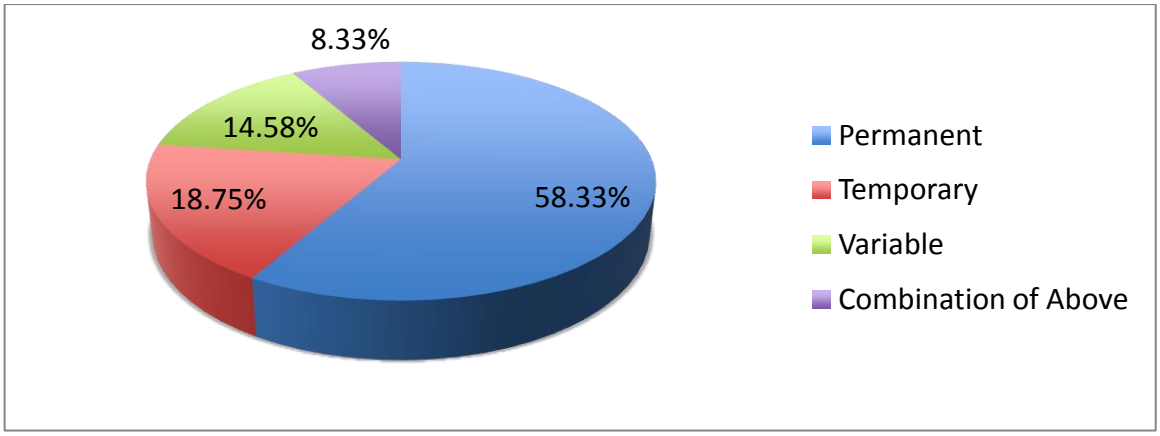
As indicated, the MOHLTC originally envisioned a system based on the Housing First model. By definition, that model describes a system of permanent housing, in which 'clients' enjoy the same rights and responsibilities[18] as any other tenant. Some of the LHINs required that ASH agencies adhere closely to that model, while others approved variations, based on their understanding of the needs of the target population in their communities.

As a result, approximately 60% of the ASH programs in Ontario can be described as providing 'permanent' housing, while nearly 20% have been designed to be 'temporary' (up to 364 days). Fifteen percent are 'variable' – based on the assessed needs of the individual tenant, and the remaining programs operate with a combination of permanent and temporary housing – with clients assigned to one or the other type based on need.

Some programs have differentiated between the duration of housing and the duration of the rent supplement. Working with clients of ASH programs from a recovery framework, these programs note that it is important to acknowledge that some people may eventually obtain permanent work that will enable them to afford market rent and disqualify them from eligibility for the rent supplement. Many of these programs have noted that rent supplements are provided *as long as they are needed*. In situations where tenants are renting from private landlords, they can choose to retain that housing, even if they no longer receive the rent supplement.

[18] As defined under the *Residential Tenancies Act (RTA).* It should be noted, however, that the *RTA* does not apply on First Nations reserves. Consequently, the units operated by the Six Nations Mental Health Program are not subject to the Act.

***Figure 5: Housing Duration***




## Housing Model

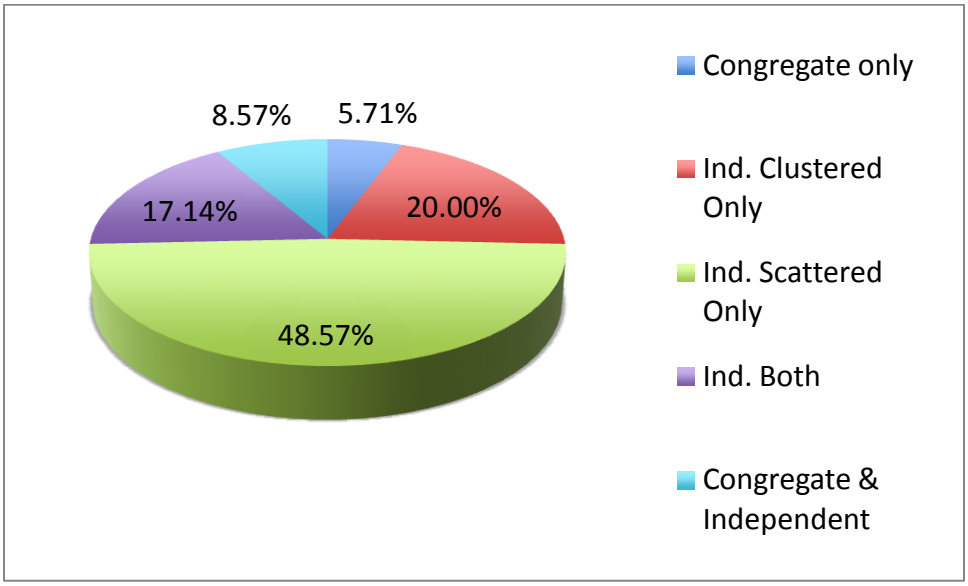
Just as there are differences among ASH programs with respect to housing duration, there is also considerable variation in terms of the housing model employed. Five models were identified:

Most programs (49%) provide independent scattered housing only (i.e. self-contained apartments located at various locations across the catchment area). The next larger number (20%) of ASH agencies offers independent clustered units only (i.e. multiple apartments located in the same building or complex), while a slightly smaller number operate both types of independent housing.

Fewer programs provide both independent and congregate housing (i.e. living situations in which each tenant has his/her own room, but shares common areas – kitchen, bath or living areas – with other tenants). Among those, many designate their congregate housing as 'transitional' and the independent units as 'permanent' - with clients moving from one to the other as they gain independent living skills.

The smallest percentage (6%) of ASH agencies offers congregate housing only.

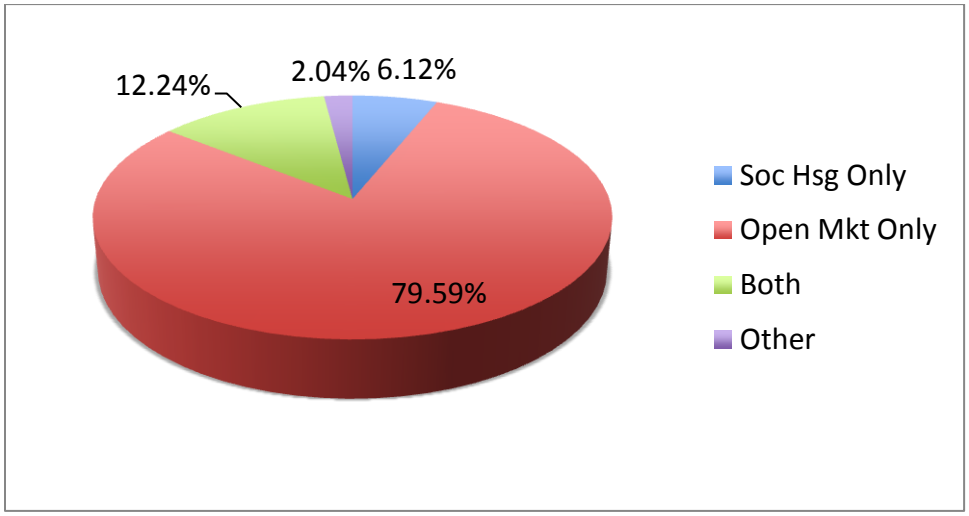
***Figure 6: Housing Model***




**Housing Type**

The vast majority (80%) of ASH programs secure their housing on the open market (i.e. from independent landlords). A small percentage has established relationships with their local municipal housing authorities - which provide independent apartments 'clustered' in a housing complex. In those cases, ASH agency staff may operate from offices in the same complex, which may also serve as an informal community 'hub' for other, non-ASH residents. Some agencies access housing of both types, while the remainder operates from units owned by not-for-profit corporations.

***Figure 7: Housing Type***

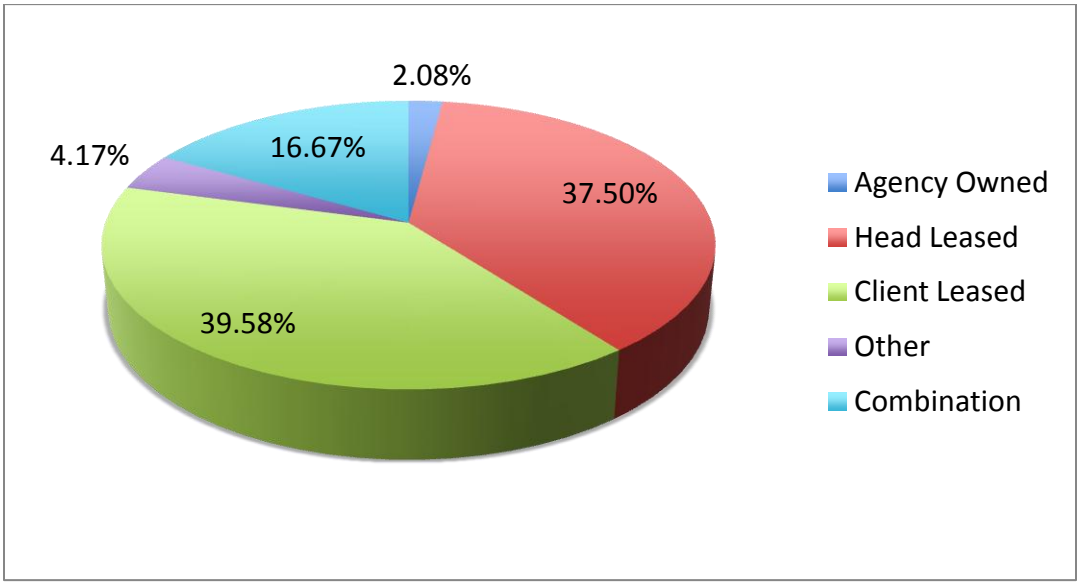



## Leasing Arrangements

Slightly less than forty percent of ASH programs operate on a model in which clients sign their own leases with the landlord. For some programs, this is simply the most expedient approach; others either expressed reservations about the liability inherent in taking on 'head leases' (in which the agency holds a 'master' lease with the landlord and the client sublets from the agency) or noted a belief in the importance of client leases as an expression of the tenant's 'ownership' of the unit and recognition of his/her responsibilities under the *Residential Tenancies Act.*

Head leases account for the second largest category (37%) while the third is comprised of units owned by the agency that provides the Rent Supplements. The remaining arrangements can be described as either 'other' (e.g. those in which no leases are signed by either party) or a combination of other types.

***Figure 8: Leasing Arrangements***




## 2.5 Case Management Services

The Case Management services offered by Ontario's ASH programs vary as much as the housing provided. Those services are described below in terms of three major variables – the staff to client ratio, the program engagement requirement, and the service delivery model.

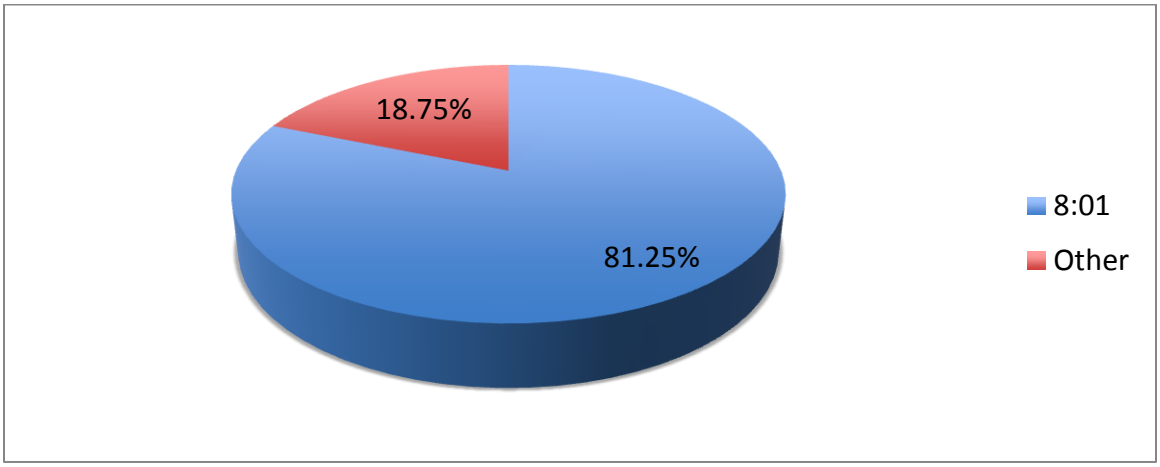
### Staff to Client Ratio

The MOHLTC specified that ASH case management services were to be funded at a ratio of one case manager for every eight clients. This relatively low service delivery ratio was intended to respond to the complex needs of the intended target population and reflect the intensity of the service to be provided. Approximately 80 percent of ASH programs operate with that ratio. Of the remainder, some cite caseloads as high as 1:12, while others describe their staffing intensity as 'variable'. Three reasons were offered for these differences:

- In programs in which the Case Management Agency funded Housing Support Workers (HSWs) employed by their Rent Supplement partner, the staff: client ratio for Case Managers was often higher than 1:8, since some of the functions typically performed by Case Managers were handled by the HSW. In one instance, the agency had opted to function with slightly fewer Case Managers in order to fund a Recreation Worker.

- In other cases, especially those in which the community's housing supply dictated a lengthy wait for an apartment, Case Managers provide services to clients on the wait list, in addition to those already housed.
- The third variation is a function of client choice. The Housing First model, on which ASH programs were based, explicitly separates housing from any requirement that tenants engage in treatment. In that model, tenants who choose not to engage with the Case Management agency are under no obligation to do so. Consequently, ASH programs that operate on that model may find that there are insufficient demands on the time of their Case Managers to justify a 1:8 ratio.

***Figure 9: Client/Staff Ratio***



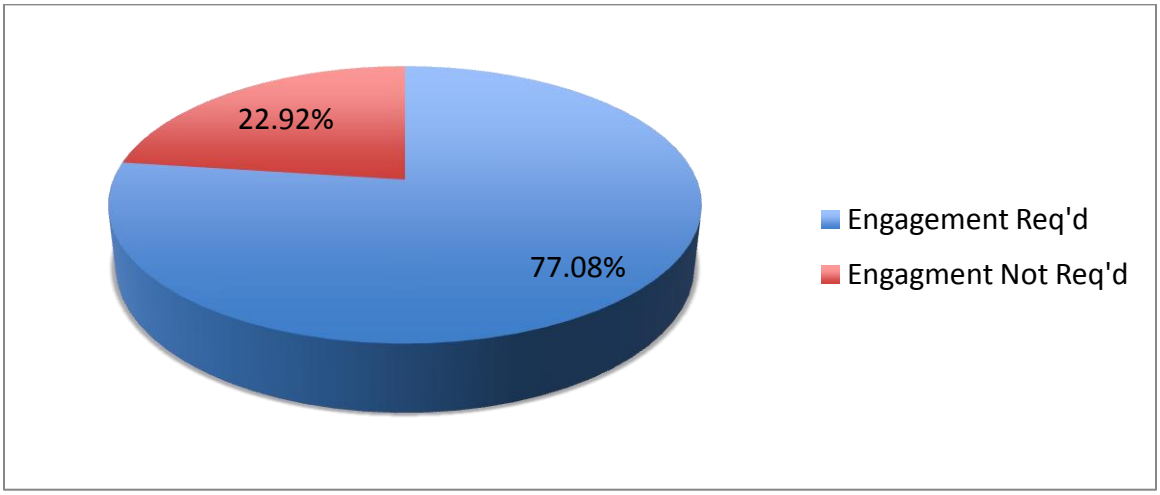

## Program Engagement Requirement

As noted above, the Housing First model dictates that tenants *not* be required to engage in treatment as a condition of tenancy. In practice, however, slightly more than three quarters of Ontario's ASH agencies have imposed some requirement that clients engage with their assigned Case Manager (if only minimally) and/or with a group operated by the agency.

Among agencies with a program engagement requirement, some indicated that they would terminate the tenancy of clients who refused contact after repeated attempts to engage them, others suggested that they would discharge the client from service, withdraw the rent supplement and inform the landlord that the rent supplement would no longer be provided. Continued tenancy would then be negotiated between the landlord and the tenant. In the remaining cases, agencies reported that there would be

no specific sanctions for clients who declined Case Management, but that they would be 'strongly encouraged' to engage.

***Figure 10: Program Engagement Requirement***

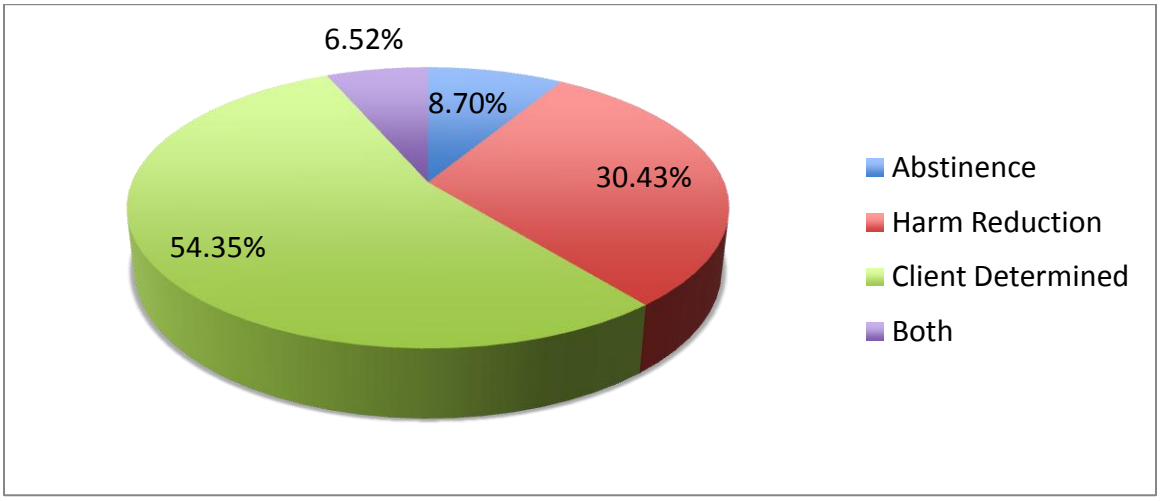



**Orientation to Substance Use Goals**

When asked to describe their program's orientation to substance use goals, a small majority of respondents (54.55%) indicated that the client him/herself determined whether a harm reduction or abstinence approach would be most helpful, and that ASH staff would support whichever approach was selected. Over 25% reported that their agency was committed to Harm Reduction[19], and used that approach exclusively, while a small percentage (6.82%) reported an 'abstinence only' orientation. The remaining programs (11.36%) noted that they supported clients in independent units who opted for Harm Reduction, but that abstinence was required in their congregate housing settings.

[19] Note that 'Harm Reduction' may include abstinence goals, if the client determines that is the best approach to reducing harm.

***Figure 11: Substance Use Goals***




## 3. Summary

This snapshot provides a high level overview of ASH programs at the time data was collected for this report. There is clearly significant variability among ASH programs, many of which have adapted their model to the meet the needs of the community and to utilize available community infrastructure and resources.

Describing ASH programs in terms of a limited number of key variables necessarily eliminates some detail and nuance; as a result, this report cannot fully capture the 'richness' and variation of these programs.

To more fully appreciate the range of approaches and individual characteristics of ASH programs, a more detailed review and analysis should be undertaken when these programs are more mature. More complex elements of ASH programs, which defy categorization, should be more fully explored in that subsequent study.

# 4. Appendices

**Appendix A: Key Informants: MOHLTC and LHINs**
**Appendix B: Questions for ASH AGENCIES**
**Appendix C: Program Profile Template**

## Appendix A: Key Informants: MOHLTC and LHINs

| AFFILIATION | NAME | DATE |
|---|---|---|
| MOHLTC | Debbie Babington | January 31/12 |
| Erie St. Clair | Dawn Maziak, Health System Design Manager | January 18/12 |
| Southwest | Patty Chapman, Planning and Integration Lead | December 7/11 |
| Waterloo Wellington | Patricia Syms-Sutherland, Senior Manager, Health System Transformation | December 12/11 |
| Haldimand Norfolk Hamilton Brant | Jenny Baretto, Advisor, Health System Transformation | January 17/12 |
| Central West | Suzanne Robinson, Planning, Integration and Community Engagement | November 29/11 |
| Mississauga Halton | Angela Jacobs, Senior Lead, Performance Team | November 28/11 |
| Toronto Central | Andrea Demers, Consultant, Health System Integration, Design and Development | December 21/11 |
| Central | Ashley Hogue, Senior Planner, Chronic Disease Management and Prevention, Mental Health and Addictions | December 2/11 |
| Central East | Jai Mills, Integration Consultant | November 25/11 |
| South East | Cate Sutherland[20] | August 2012 |
| Champlain | Louise Grenier, Lead, Mental Health and Substance Abuse | November 29/11 |
| North Simcoe Muskoka | Lynn Huizer, Senior Manager, Health System Integration | January 23/12 |
| North East | Michael O'Shea, Mental Health Lead | January 23/12 |
| North West | Susan Pilatzke, Senior Director, Health System Transformation | December 18/11 |

[20] Rick Giajnorio, Senior Consultant, South East LHIN, referred our inquiry to Cate Sutherland, Executive Director, Addiction Services of Eastern Ontario

## Appendix B: Questions for ASH AGENCIES

NAME:

_____

AGENCY:

_____

☐ Did your agency receive funding for: (please circle)

- ◘ Case management? Yes No
- ◘ Rent supplements? Yes No
- ◘ Administration of the ASH program? Yes No

☐ If so, how much:

- ◘ For case management?

  $ _____

- ◘ For rent supplements?

  $ _____

- ◘ For administration?

  $ _____

***If your agency was funded to provide case management:***

- ☐ When was funding announced?

- ☐ When did funding flow?

- ☐ How many FTEs were approved?

- ☐ What is the client/staff ratio?

- ☐ When did you see your first client?

- ☐ How many clients are you seeing?

- ☐ What type of service are you providing?

- ☐ Which agency is administering the rent supplements for your clients?

***If your agency received funding for rent supplements:***

- ☐ When was funding announced?

- ☐ When did funding flow?

- ☐ How many rent supplements were provided?

- ☐ How many units are currently occupied?

- ☐ What type of housing are you providing?

- ☐ Which agency is providing case management services to tenants in your units?

***For all ASH agencies:***

- ☐ Is your agency doing anything unique/different/ground breaking in the context of ASH? (Please forward details by e-mail to mamrjean@google.com

- ☐ If you are 'partnered' with another agency to deliver ASH services, do you have a formal partnership agreement?

- ☐ What implementation issues/ challenges (if any) have you encountered to date?

- ☐ Do you see other issues on the horizon? If so, please specify

## Appendix C: Program Profile Template

# ASH PROGRAM REVIEW - GENERAL

**1. LHIN**

**2. AGENCY**

**3. FUNDED FOR: (check one)**

**Rent Supplement** ☐

**Case Management** ☐

**Both** ☐

**4. NUMBER OF UNITS/ CASE MANAGERS:**

**5. DATE FIRST TENANT MOVED IN**

**6. PRIMARY REFERRAL SOURCES**

**7. NAME OF AGENCY ADMINISTERING RENT SUPPLEMENT (Where applicable)**

**8. ADMINISTRATIVE FUNDING PROVIDED?**

**Yes** ☐ **Amount:**

**No** ☐

**9. TARGET POPULATION/ELIGIBILITY CRITERIA**

**10. NOTES**

# ASH PROGRAM REVIEW - HOUSING

**1. HOUSING MODEL: (Check all that apply)**

**Congregate** ☐

**Independent Clustered** ☐

**Independent Scattered** ☐

**2. DURATION: (Check one)**

**Temporary** ☐ **How long?**

**Permanent** ☐

**Variable** ☐

**Notes:**

**3. TYPE OF HOUSING: (Check all that apply)**

**Open Market** ☐

**Social Housing** ☐

**4. LEASING ARRANGEMENTS (Check all that apply)**

**Agency owned** ☐

**Head lease** ☐

**Client holds own lease** ☐

**Other** ☐ **Specify:**

**5. ROLE OF HOUSING PROVIDER: (Check all that apply)**

**Flow through for rent supplement only** ☐

**Secure housing** ☐

**Hold head lease** ☐

**Manage relationship with landlord** ☐

**Provide ADL support to client** ☐

**6. CONDITIONS OF TENANCY (e.g. 'no pets', involvement in programming)**

**7. NOTES**

## ASH PROGRAM REVIEW – CASE MANAGEMENT

**1. CLIENT/STAFF RATIO**

**8:1** ☐

**Other** ☐ **Specify:**

**2. CLIENT ENGAGEMENT REQUIREMENT: (check one)**

**Yes** ☐ **Individual?** **Group?**

**No** ☐

**3. TARGET FREQUENCY OF CONTACT: (check all that apply)**

**Q 1 week** ☐

**Q 2 weeks** ☐

**Q 1 month** ☐

**Other** ☐

**At request of client** ☐

**4. APPROACH: (check one)**

**Harm Reduction only** ☐

**Abstinence only** ☐

**Client-determined** ☐

**5. CRITERIA FOR TERMINATION OF SERVICE**

**6. NOTES**